

DELTA Dental Plan

	DELTA	
Choice of Dentist	Choose any dentist you wish for services and receive applicable benefits. Save the most with a Delta Dental PPO network participating dentist. Percentages below are based on Delta's applicable allowances and not the dentist's actual charge. Payments to non preferred providers are based on Reasonable and Customary (not billed) charges.	
Maximum Benefit/Deductible	\$1,000 per year per person \$50 deductible per year per person; \$150 family maximum	\$1,500 per year per person \$50 deductible per year per person; \$150 family maximum
Type I 0150 Comprehensive Oral Evaluation -New or Established 0120 Periodic Oral Exam X-rays 1110/20 Prophylaxis 1203 Fluoride Treatment (children up to the age 19) 1351 Sealant - per tooth 1510 Space Maintainers	STANDARD Plan Pays (No deductible) 100% 100% 100% 100% (Twice per calendar year) 100%, 2x per year 100% to age 16 100% to age 19	ENRICHED Plan Pays (No deductible) 100% 100% 100% 100% (Twice per calendar year) 100%, 2x per year 100% to age 16 100% to age 19
Type II Fillings: (silver) 2330 one surface 2331 two surfaces 2332 three surfaces 2335 four or more surfaces Root canals: 3310 Anterior 3320 Bicuspid 3330 Molar 3410 Apicoectomy Extractions: 7111 Single tooth 7140 Extraction, erupted tooth or exposed tooth 7210 Surgical extraction of erupted tooth Periodontics: (gum treatment) 4341 Periodontal scaling & root planning-per quadrant 4210 Gingivectomy/gingivoplasty - per quadrant 4910 Periodontal maintenance procedures	 * 100% PDP/ 75% NON PDP 100% PDP/ 75% NON PDP 100% PDP/ 75% NON PDP 100% PDP/ 75% NON PDP 75% 75% 75% 75% 75% 75% 75% 75% 75% 75%	 * 100% PDP/ 75% NON PDP 100% PDP/ 75% NON PDP 100% PDP/ 75% NON PDP 100% PDP/ 75% NON PDP 75% 75% 75% 75% 75% 75% 75% 75% 75% 75%
Type III Crown & Bridge 2930 Prefabricated stainless steel primary tooth 2791 Crown full cast predominately base metal 2751 Crown Porcelain fused to base metal Pontics: 6210 Full cast 6240 Porcelain fused to metal Prostodontics (Dentures) 5110 Complete upper 5120 Complete lower 5213/14 Partial upper or lower - cast metal base	 * 50% 50% 50% 50% 50% 50% 50% 50%	 * 50% 50% 50% 50% 50% 50% 50% 50%
ORTHODONTIA Consultation Evaluation Records Children - Normal Class II Adult - Normal Class II 8750 Retention	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Adult & Children covered at 50% after a one time deductible of \$50 per person. \$1,000 lifetime maximum
VISION Examination Single Vision Lenses Bifocal Lenses Trifocal Lenses Contact Lenses - Non-Elective Contact Lenses - Elective Frames	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered

* All Type II and III charges subject to annual deductible

* The above reimbursements are exclusive of gold.

ADP & OHS Dental Plans

AMERICAN DENTAL PLAN (ADP) Now known as CompBenefits		ORAL HEALTH SERVICES (OHS) Now known as CompBenefits	
Limited to Participating Dentists in Private Practice		Limited to Participating Dentists in Private Practice	
No Maximum No Deductible		No Maximum No Deductible	
STANDARD You Pay* No Charge No Charge No Charge No Charge (Once every 6 months) No Charge 7.00 35.00	ENRICHED You Pay No Charge No Charge No Charge No Charge (Once every 6 months) No Charge 7.00 35.00	STANDARD You Pay No Charge No Charge No Charge No Charge (Once every 6 months) No Charge 6.00 40.00	ENRICHED You Pay No Charge No Charge No Charge No Charge (Once every 6 months) No Charge No Charge No Charge
No Charge No Charge No Charge No Charge 95.00 135.00 175.00 65.00 No Charge No Charge 20.00 37.50 105.00 UCR Less 25%	No Charge No Charge No Charge No Charge 95.00 135.00 175.00 65.00 No Charge No Charge 20.00 37.50 105.00 35.00	No Charge \$11.00 \$16.00 \$18.00 90.00 155.00 200.00 75.00 No Charge No Charge 15.00 40.00 120.00 25.00	No Charge No Charge No Charge No Charge 45.00 90.00 145.00 65.00 No Charge No Charge No Charge 40.00 90.00 25% Discount
35.00 185.00** 200.00** 185.00** 200.00** 200.00 200.00 250.00	35.00 185.00** 200.00** 185.00** 200.00** 200.00 200.00 250.00	25.00 \$210.00 \$210.00 25% Discount 25% Discount 230.00 230.00 275.00	No Charge \$175.00 \$175.00 25% Discount 25% Discount 205.00 205.00 240.00
No Charge UCR Less 25% UCR Less 25% UCR Less 25% UCR Less 25% Additional	No Charge 35.00 250.00 1400.00 1950.00 Additional	25% Discount 25% Discount 25% Discount 25% Discount 25% Discount 25% Discount	No Charge 25.00 200.00 1,400.00 1,950.00 25% Discount
Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	10% Discount 20% Discount 20% Discount 20% Discount 20% Discount 20% Discount 20% Discount

* STD Plan fee apply to participating General Dentist only.

** Co-payments are exclusive of gold.

* Cost of high noble metal additional.